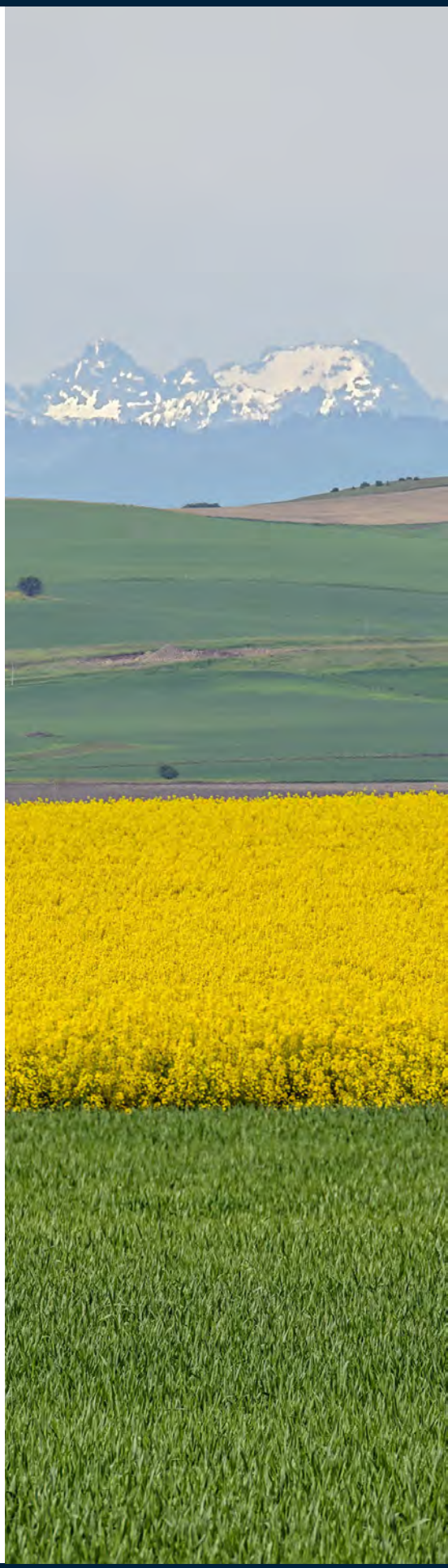
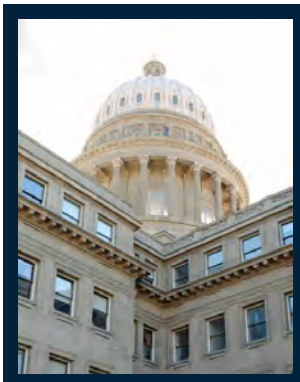
Evaluation report 16-01
January 2016

Design of the Idaho Behavioral Health Plan



Office of Performance Evaluations
Idaho Legislature



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From the director

January 13, 2016

Members
Joint Legislative Oversight Committee
Idaho Legislature

The lessons and recommendations we discuss in this report are directed to the Department of Health and Welfare. However, these recommendations are equally useful for all state agencies that design and implement complex policies.

We have found in this evaluation and several prior evaluations insufficient communication and underdeveloped program design to be common shortcomings, especially when contracting for program implementation. To a large degree, these shortcomings can be addressed through careful and deliberate planning.

When the expertise necessary for planning is absent in-house, we highly recommend that state agencies use independent third-party expertise. Additional expertise may be needed for monitoring the contract and assessing deliverables. Agencies should consider the cost of planning and expertise as an investment toward ensuring successful policy implementation.

We appreciate the cooperation and assistance of the department and Optum in conducting this study. Also, we are grateful to the service providers whose valuable feedback helped us understand what was actually happening on the ground and how they were affected by the design of the Idaho Behavior Health Plan.

Sincerely,

Rakesh Mohan, Director
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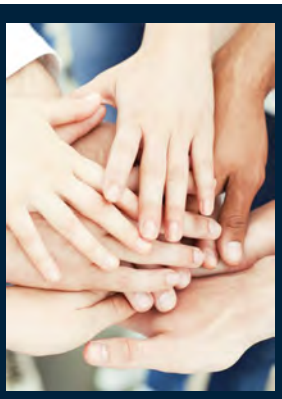
Included in the back of the report are formal responses from the Governor, the Department of Health and Welfare, and Optum Idaho.



Lance McCleve and Ryan Langrill conducted this study.

Margaret Campbell copy edited and desktop published the report.

Bob Thomas, consultant, conducted a quality control review.

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Executive summary

Legislative interest

The department, in early 2012, presented a plan to move the administration of outpatient behavioral health services to managed care. The department's plan came in response to legislative direction from 2011 House Bill 260. The culmination of the department's plan was the Idaho Behavioral Health Plan, which went live in September 2013. Startup concerns involving payments and call hold times brought the plan to the Legislature's attention during the 2014 legislative session. Concerns persisted into the 2015 legislative session and led some legislators to suspect that program design, not contract compliance issues, was driving concerns.

Clarifying sources of concern

The department hoped that managed care would help the behavioral health system move toward improved services, evidence-based practices, and a broader array of services. All of the changes the department hoped would be brought about by the Idaho Behavioral Health Plan required providers to make changes to their practices. The department's changes to policy, service criteria, and oversight required some providers to make major changes in their business and clinical models. A large portion of vocal concern came from providers who were unhappy with aspects of these changes.

Adding to these providers' frustration, the Idaho Behavioral Health Plan dramatically reduced spending on services they specialized in providing. Some of these providers believed Optum was capriciously targeting these services by using criteria that were too narrow in its clinical reviews—narrow criteria that providers believed prevented them from supplying needed services.

We do not want to diminish the experiences these providers have had with the Idaho Behavioral Health Plan. Intentional policy changes, reduced spending, and increased oversight combined with unintentional transitional challenges have affected many of them in significant and negative ways.

We emphasize that the changes to policies, service criteria, and oversight, which have negatively affected some of these providers, were all intentionally included in the Idaho Behavioral Health Plan by the department. The department was aware that the program would negatively affect some providers, but it believed changes were necessary to reform Idaho's public behavioral health system.

Results of Idaho's behavioral health plan

Overreliance on or misuse of psychosocial rehabilitation (PSR) was a major concern of the department and a strong influence on the department's decision to incorporate managed care into its behavioral health system. The department's desire to reallocate resources led the department to a unique managed care configuration: Idaho chose not to include inpatient care in its managed care contract, making Idaho the only state with a statewide behavioral health carveout that excludes inpatient care.

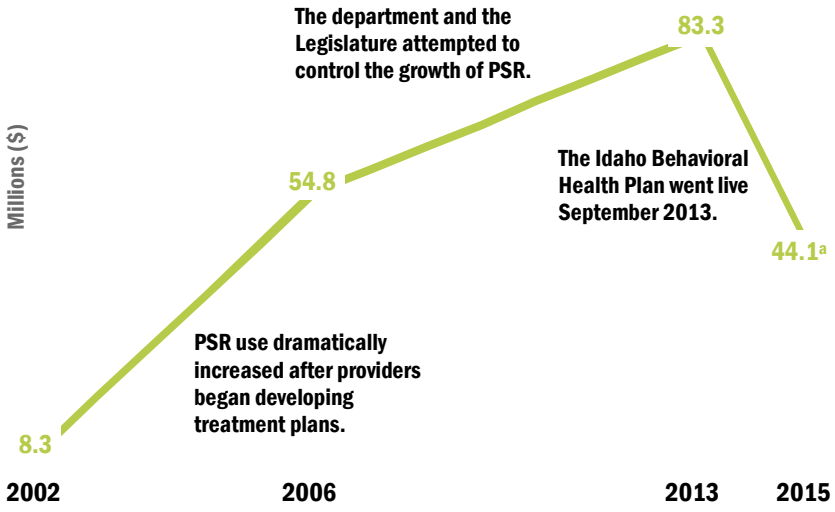
Overreliance on PSR was a major concern of the department and a strong influence on the department's decision to incorporate managed care into its behavioral health system.

Idaho chose not to include inpatient care in its managed care contract, making Idaho the only state with a statewide behavioral health carveout that excludes inpatient care.

National experts suggest that managed care best improves the quality of care and saves money when a single entity is responsible for the entire continuum of care, from outpatient to inpatient. Because inpatient care is expensive when compared with community-based services, the managed care vendor has a high reward for identifying members likely to use inpatient care and providing services that are less restrictive and more appropriate.

The department explained that the primary reason it excluded inpatient services was because it worried that "managed care contractors might choose the standard approach of focusing on the hospital [inpatient services] rather than on the issues with PSR." In July–August 2013, the Division of Medicaid spent four times more for members to receive PSR than it spent on inpatient care. The significant and unusual amount of spending on PSR gave Idaho an opportunity to reallocate resources without relying on inpatient savings.

Medicaid spending on PSR increased through 2013, a trend reversed by the Idaho Behavioral Health Plan.



a. 2015 data extrapolated from Optum claims data. Changes in spending also reflect the department's redefinition of the service to community-based rehabilitation services in 2013.

Implementation of the Idaho Behavioral Health Plan has led to a decrease in overall spending—approximately an annualized $28 million less than the department was spending before adopting the Idaho Behavioral Health Plan. The majority of savings have come from decreased reliance on PSR.

In addition to reducing reliance on PSR, the department wanted the plan to improve the continuum of care and service integration. There has been limited success in both areas as a result of the restrictive nature of federal regulations and workforce development difficulties. However, the significant decline in PSR has been accompanied by smaller increases in other outpatient services, especially family therapy. As of March 2015, family therapy was being provided to more children than was PSR.

One concern of moving to managed care has been that people denied services under the Idaho Behavioral Health Plan would end up accessing other state services. We analyzed data from the Division of Medicaid and the Division of Behavioral Health and found no evidence that changes in Idaho Behavioral Health Plan services led to increases in service use elsewhere.

In addition to reducing reliance on PSR, the department wanted the plan to improve the continuum of care and service integration. There has been limited success in both areas.

The department's lessons are valuable to all state agencies when designing complex policies that depend on contracting.

Lessons

The Idaho Behavioral Health Plan was the department's largest managed care effort and a significant change for the public behavioral health system. Both the successes and shortcomings provide lessons from the department's experience implementing the Idaho Behavioral Health Plan.

The department's lessons are valuable to all state agencies when designing complex policies that depend on contracting for successful implementation of those policies.

Clearly communicate plans and choices for key aspects of new programs.

We found a widespread lack of understanding of the department's choices leading up to managed care within the department, the Legislature, and the community. The department has acknowledged that, while it believed it had sufficient plans for communication with stakeholders, there was never such a thing as enough communication when undergoing a change of this magnitude. More communication with stakeholders could prevent confusion about the objective and likely impacts of the change.

Program design should be well developed before going to contract.

Agencies are limited in their ability to shape a program after a contract is awarded. When contracting, the resources spent developing and implementing a plan should be proportional to (1) the amount of management responsibility an agency outsources when contracting and (2) the importance of the contract to program success.

Before deciding to contract, agencies should complete a program analysis to understand not just what the vendor will be responsible for, but what the agency will continue to be responsible for and what it will be newly responsible for.

A key part of program design is ensuring sufficient subject matter and business expertise to design, implement, and manage the program through a contractor. When agencies first transition from delivering services in-house to delivering services through a vendor, a common failure is using the same personnel and skills

to plan, contract, and manage the delivery of services by a vendor that the department had used to manage and deliver services in-house. The skills necessary to plan and manage a project and to write and enforce a contract are distinctly different from those necessary to directly provide the service.

The department or any agency engaging in a complex program that primarily relies on contracting should make sure it has the skillset and expertise appropriate for the task. Although the department relied on existing program staff to develop and monitor the plan and contract, it has since taken steps to strengthen its contract monitoring process and team.

Expect some difference between program design and vendor's products, and plan for necessary adjustments.

The department has learned that vendors often have fairly well-defined products and capabilities. No product will perfectly align with a program's design and needs. Vendors will generally have to customize their products to some degree. However, if the services or approaches asked for fall outside a vendor's capabilities, the department would be likely to pay more for them and the vendor would likely struggle with how to implement them.

Recommendations

Integrating payment for the entire continuum of care can be a good step to integrating care for members, a major goal of the department. By putting a vendor at risk for the entire continuum of care, the vendor has incentive to develop more levels of care and smoother transitions for patients between levels of care.

Although there are potential benefits from integrating payment for the entire continuum of care, we recognize there may be Idaho-specific barriers and concerns. Additionally, the population served by behavioral health services is vulnerable and requires policy to be implemented with caution.

To determine whether to expand the Idaho Behavioral Health Plan to the full continuum of care, we recommend the department formally evaluate the merit of including inpatient services in the Idaho Behavioral Health Plan.

We recommend the department formally evaluate the merit of including inpatient services in the Idaho Behavioral Health Plan.

We also recommend the department use independent third-party expertise for assistance in planning and designing the transition.

The evaluation should include clear documentation of the department's reasons and goals for either including or excluding inpatient services. The department's decision whether to include or exclude inpatient services will determine the mechanisms available for reform. Therefore, the department should compare the mechanisms available in each option and determine which option most effectively meets the behavioral health system's needs. In addition, the evaluation should clearly document expectations, barriers, and resource needs. We also recommend the department use independent third-party expertise for assistance in planning and designing the transition.

A deliberate approach such as this should be taken, not just for deciding whether to include inpatient services, but for any project of this size, complexity, or level of risk. A formal evaluation will enable the department to make a deliberate, informed decision and

clearly communicate plans and choices for key aspects of new programs;

have a well-developed program design before going to contract; and

expect some difference between program design and vendor's products and plan for necessary adjustments.

Medicaid

Title XIX of the Social Security Act is known as Medicaid. It became law in 1965 and is jointly funded by states and the federal government. Medicaid is the largest source of funding for health care for people with low incomes. States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. In Idaho, Medicaid is administered by the Division of Medicaid in the Department of Health and Welfare. Federal administration is done by the Centers for Medicare and Medicaid Services.

The federal government requires states to cover certain eligibility groups, such as children in low-income families and anyone receiving Supplemental Security Insurance (SSI). States may also cover other eligibility groups, such as low-income adults between the ages of 19 and 64.

Introduction

1

Legislative interest

In House Bill 260 in 2011, the Legislature directed the Department of Health and Welfare to develop a plan for moving Medicaid behavioral health to managed care with the objective of developing an accountable system of care and present its plan to the Legislature in 2012.

In early 2012 the department presented its plan to the Legislature and released a request for proposals in August 2012; final bids arrived in December 2012. Optum won the 3-year contract estimated at $300 million, and managed care went live in September 2013 as the Idaho Behavioral Health Plan. Startup concerns involving payments and call hold times brought the Idaho Behavioral Health Plan to the Legislature's attention during the 2014 legislative session. The department recognized these concerns and worked with Optum to address them.

Concerns continued through the 2015 legislative session. In response to legislative questions about continued concern, the department said it believed that Optum's overall performance was acceptable according to contract criteria. Some legislators suspected that instead of contract compliance issues, program design may have been driving concerns. In March 2015 the Joint Legislative Oversight Committee approved an evaluation request for us to examine the department's design and implementation of the Idaho Behavioral Health Plan. The evaluation request is in appendix A.

Distinguishing between the effects of program design and the effects of operational performance is important for moving forward.

Evaluation approach

When developing our scope, available in appendix B, we found questions in the evaluation request fell into two categories: operational performance and program design.

We designed our evaluation to help identify whether the Idaho Behavioral Health Plan is achieving the results expected by the department and to identify factors that have had a significant positive or negative effect on program success. Aspects of both operational performance and program design have contributed to concern about the Idaho Behavioral Health Plan and Optum's delivery of the plan. However, distinguishing between the effects of program design and operational performance is important for moving forward.

We acknowledge the role that operational performance has played in the implementation of the Idaho Behavioral Health Plan. However, we found that the department's program design is the most significant factor affecting the results the Idaho Behavioral Health Plan has achieved and could be expected to achieve. Therefore, we have focused our report on program design. Our methodology is in appendix C.

We used four key sources as a basis for understanding stakeholder priorities and the intended direction of reform efforts for Idaho's behavioral health system:

1. Report of the Western Interstate Commission for Higher Education (WICHE). This report was commissioned by the Legislature in 2007 to provide a comprehensive review of the public behavioral health system.

2. Work of the Governor's Behavioral Health Transformation Work Group. The work group included representatives from the executive and judicial branches and private-sector stakeholders.

3. House Bill 260 of the 2011 Idaho Legislative Session.

4. Contracting and monitoring documentation from the department.

Clarifying sources of concern

2

Medicaid is the largest source of public behavioral health spending in Idaho—$189.3 million in services for fiscal year 2014—and the Idaho Behavioral Health Plan significantly changed the way spending is administered. Some transitional difficulties were natural given the scale of program and policy changes. A large portion of vocal concern about operational performance came from providers who were unhappy with changes to policy, service criteria, or oversight.

The transition challenges amplified the concern of those unhappy with changes to policy, service criteria, or oversight. Although the focus of this report is the department's design and implementation of the Idaho Behavioral Health Plan, understanding the transition challenges and the experience of providers unhappy with the department's plan is necessary for understanding the full context of the attention given to the Idaho Behavioral Health Plan.

Provider concern over implementation challenges have carried over to and amplified other concerns.

During the first months of managed care, some providers were paid pennies on hundreds of dollars owed. Optum quickly acknowledged and resolved this issue. Some providers also reported that Optum had paid (or continued to pay) slowly compared with payment times before Optum. Although these initial payment issues were not contract violations, they were the cause of some provider frustration.

Providers also reported spending significant time on the phone when requesting prior authorization for services. Problems involving call wait times persisted into 2014 because Optum did not anticipate the volume of daily authorization requests. In Optum's efforts to improve call wait times, it identified root causes as "staffing model, method of review, triggers for review, identification of essential information necessary to process a call, efficiency of Care Advocate call handling, provider lack of familiarity of managed care, and lack of specificity in the Level of Care Guidelines for Idaho's services."

The department's contract monitoring team was aware of any concerns that we were aware of.

The department noted that Optum had been responsive in addressing the root causes identified. The department also said it consistently agreed with the clinical judgments made in Optum's authorizations or denials. Nevertheless, transition issues appeared to create significant confusion about criteria for prior authorization among some providers.

We pursued several leads regarding concerns about Optum's operational performance. We found the department's contract monitoring team was aware of any concerns that we were aware of. We have observed a marked improvement and constant revision of the department's contract monitoring strategy.

The Idaho Behavioral Health Plan has negatively affected some providers specializing in certain services, such as psychosocial rehabilitation.

Managed care, as the department intended it to be implemented, required some providers to make major changes to their business and clinical models. Idaho's managed care includes additional processes and procedures to assess the quality and evidence base for services provided to members. One of these procedures requires providers to submit documents justifying why they are requesting certain services for treating a given member. The additional documentation and information allowed for clinical reviews to determine whether each member was receiving the right treatment.

Many treatment options under the Idaho Behavioral Health Plan did not require clinical review prior to providing services and did not require significantly more administrative effort by providers of those services. However, providers specializing in services, such as psychosocial rehabilitation (PSR), that required clinical review before services were provided had reported increased administrative burden caused by the length of the documentation required for service authorizations.

Adding to these providers' frustration, the Idaho Behavioral Health Plan had dramatically reduced spending on the services they specialized in providing. We heard from providers specializing in these services. Many of them believed Optum was capriciously targeting these services through clinical reviews using criteria that were too narrow. These providers believed that the narrow criteria prevented them from supplying needed services.

We do not want to diminish the experiences these providers have had with the Idaho Behavioral Health Plan. Operational changes and performance difficulties combined with reduced spending and increased oversight have affected many of them in significant and negative ways.

We cannot comment on the appropriateness of Optum's criteria for clinical review. However, we emphasize that changes to

The department was aware that the program would negatively affect some providers but believed that changes were necessary to reform Idaho's behavioral health system.

Changes to policies, service criteria, and oversight, which have negatively affected some providers, were intentionally included by the department as part of the Idaho Behavioral Health Plan.

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Additionally, the department was aware that the program would negatively affect some providers but believed the changes were necessary to reform Idaho's public behavioral health system.

Medicaid services

States must provide the following services as part of their Medicaid benefit package:

- Inpatient hospital services
- Outpatient hospital services
- Pregnancy-related services
- Vaccines for children
- Physician services
- Nursing facility services for individuals 21 years or older
- Family planning services and supplies
- Rural health clinic services
- Home health care for individuals eligible for skilled nursing services
- Laboratory and x-ray services
- Pediatric and family nurse practitioner services
- Nurse midwife services
- Federally qualified health center services and ambulatory services of a federally qualified health center that would be available in other settings
- Early and periodic screening, diagnostic, and treatment services for children under age 21
- Home health services
- Transportation to medical care
- Tobacco cessation counseling for pregnant women

Idaho's behavioral health plan

3

The department's decision to incorporate managed care into its behavioral health system was strongly influenced by the growth or misuse of psychosocial rehabilitation (PSR). The department's desire to reform PSR led it to pursue managed care and its unique approach to managed care. The department's unique approach was to carveout the administration of outpatient services from inpatient services.

Idaho's behavioral health system lacked resources to provide oversight and accountability.

Work by WICHE and the Governor's work group found that Idaho's public behavioral health system was overly reliant on high-cost inpatient care, crisis care, and incarceration to meet demands for community-based services. WICHE and the Governor's work group also found that the department's oversight of community providers was insufficient or nonexistent.

The department attempted to implement requirements to ensure members received services that were medically necessary and appropriate. However, as WICHE found, the department lacked resources to strategically monitor providers; the lack of resources also limited the effectiveness of the department's efforts to oversee and administer all benefits. The work group found the department's service standards inconsistent.

Psychosocial rehabilitation is now community-based rehabilitation services

The service we refer to as psychosocial rehabilitation (PSR) was replaced with community-based rehabilitation services (CBRS) in preparation for the move to managed care in 2013, which allowed the department to define the service and limits more effectively. Throughout the report, we discuss this service both before and after the transition to CBRS. For consistency, we have chosen to use the term PSR.

The department's reliance on self regulation by providers led to disproportionate use of a single service: PSR.

Before making significant changes in 2002, department staff developed members' treatment plans. A member's treatment plan could include up to 20 hours of PSR per week. Before 2002, spending on PSR was stable: in 2000 spending on PSR was $8.6 million and in 2001 spending was lower, at $8.3 million.

During 2002 the department cut clinical staff and gave private providers responsibility to develop treatment plans. The department was concerned that the decision to give providers responsibility to develop treatment plans had allowed the uses of PSR to change. In addition to treating mental illness, PSR was sometimes inappropriately used to replace missing social services.

The department used three methods in its attempts to rein in PSR: incrementally lowering the maximum hours allowed from 20 hours per week to 4, increasing fraud prevention activities, and implementing a utilization management program.

As shown in exhibit 1, the department's policy decisions in the early 2000s led to significant growth in PSR from 2001 to 2012. In 2002 spending doubled to $17.7 million. By 2012 the Division of Medicaid's spending on PSR had increased to $76.1 million—more than nine times the spending in 2001.

During this time, if PSR had grown at the rate psychotherapy had grown, the department would be spending approximately $50 million per year less on PSR than it had before transitioning to managed care. Because the department believed that other outpatient services would better treat mental illness, it wanted to reallocate resources accordingly.

See appendix D for details of the department's efforts to rein in PSR.

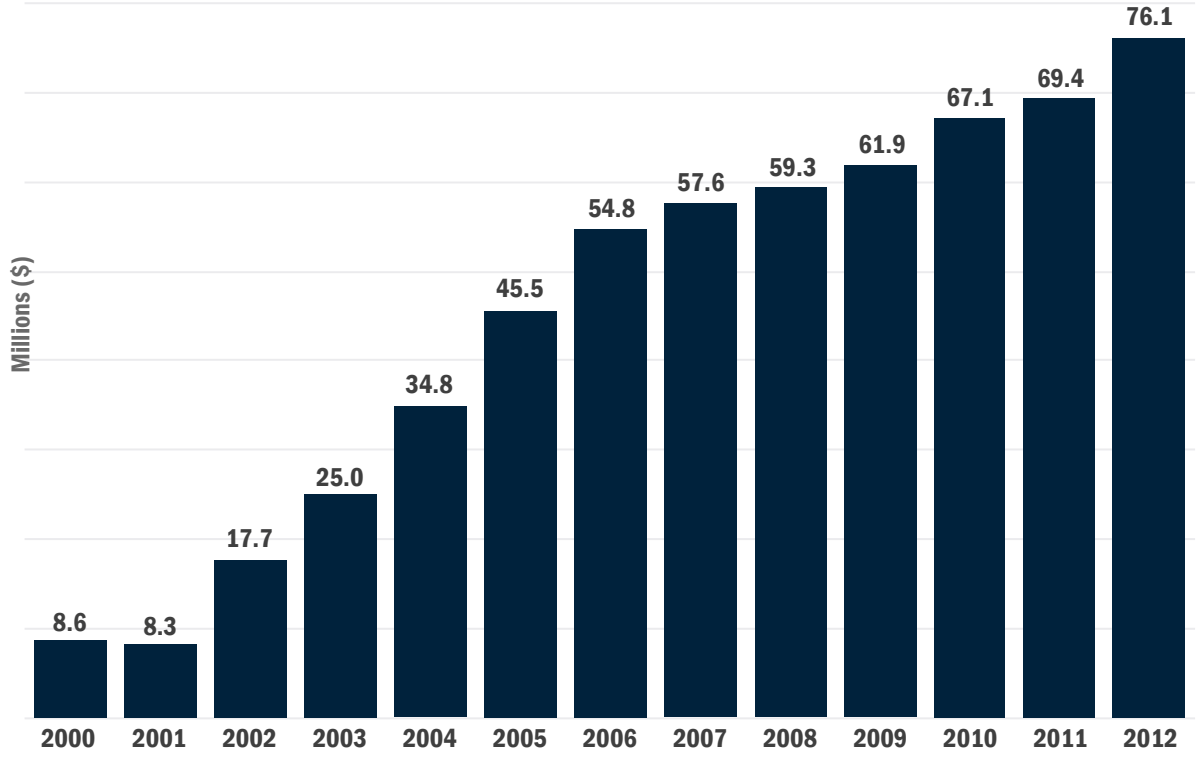
By 2012, 65% of the division's outpatient behavioral health spending was on PSR.

The department was concerned that the decision to give providers responsibility to develop treatment plans had allowed the uses of PSR to change.

Exhibit 1

Medicaid spending on PSR increased ninefold from 2001 to 2012.

The division put providers in charge of treatment plans in 2002.



Other public health programs

The Children's Health Insurance Program (CHIP) covers certain children in low-income families not covered by other sources. In Idaho, CHIP is administered as an extension of Medicaid. When we refer to Medicaid in this report, we include CHIP. It is jointly funded by states and the federal government.

Medicare is a program administered by the federal government that provides health coverage for the elderly and certain younger groups. No state money goes to Medicare. Medicare and Medicaid are entirely distinct, but some people are eligible for both programs.

The department's plan transitioned behavioral health from a fee-for-service payment model to a managed care system.

The department had administered Medicaid's behavioral health benefit entirely as fee-for-service payment model until it implemented the Idaho Behavioral Health Plan in September 2013. Under the Idaho Behavioral Health Plan, the department transitioned most Medicaid outpatient behavioral health care to managed care administered by Optum.

The department hoped the Idaho Behavioral Health Plan would bring PSR back in line with the department's vision for this service. WICHE and the Governor's work group had suggested the state explore managed care. The department hoped managed care would help the behavioral health system move toward the vision of improved services, evidence-based practices, and a broader array of services expressed by WICHE and the Governor's work group.

Fee-for-service payment model

Under Medicaid fee-for-service system, the state lists services and limitations to services it will pay for in its state plan. Payment amounts are determined by a fee schedule set by the state. The Center for Medicaid and Medicare Services approves states' method for rate setting. When providers treat a qualified member and bill for the service, the state pays it.

Idaho has two major Medicaid plans: basic and enhanced. Members with disabilities or special health needs qualify for the enhanced plan, which has different services and limitations. Until the implementation of the Idaho Behavioral Health Plan, these plans covered outpatient behavioral health services as a fee-for-service payment model, which included psychotherapy (individual, family, and group), psychosocial rehabilitation, drug screening, partial care, medication management, psychological testing, and neuropsychological testing. Behavioral health inpatient care, which is still administered as a fee-for-service payment model, includes long-term and short-term institutional care.

The department hoped the Idaho Behavioral Health Plan would bring PSR back in line with the department's vision for this service.

The Idaho Behavioral Health Plan is a risk-based, limited benefit plan covering outpatient behavioral health care for Idaho's Medicaid members.

The Legislature's goal with introducing managed care tools to Medicaid was to improve efficiency, health outcomes, and move toward accountable care.

Managed care

The managed in managed care indicates some point on a continuum of active management of services and the service delivery network. Traditional fee-for-service payment methods generally involve less active management than payment methods considered managed care. Health care payment systems that are generally considered to be managed care systems incentivize providers or network managers to take a more active role in managing services and service delivery within a health care network.

Managed care has been part of the Medicare and Medicaid delivery system since the 1970s, and its use continues to increase in prevalence. The Centers for Medicare and Medicaid Services reported in 2015 that about 80 percent of all Medicaid members nationwide were enrolled in some managed care program.

Medicaid allows three primary types of managed care arrangements:

Comprehensive risk-based plans cover all or most Medicaid covered services.

Limited benefit plans cover a subset of benefits, such as transportation or behavioral health, or cover services for a particular population, such as medically fragile adults or children in foster care. These plans may be risk based.

Primary care case managers are contracted to manage care as a client's single designated primary care provider and are paid a monthly case management fee for care management and coordination.

The Idaho Behavioral Health Plan is a risk-based, limited benefit plan covering outpatient behavioral health care for Idaho's Medicaid members. The Legislature's goal with introducing managed care tools to Medicaid was to improve efficiency, health outcomes, and move toward accountable care.

Under Idaho's risk-based, limited-benefit plan, a third-party vendor agrees to cover all included benefits for Medicaid members in exchange for a fixed payment per member per month. The payment is set before services are delivered, so the payment is not adjusted for the vendor's actual costs. The vendor is at risk because its costs may exceed its payment.

The Division of Medicaid paid Optum $39.59 each month for each member not eligible for Medicare, and it paid $107.19 each month for each member who was eligible. By paying a flat fee, the state transferred the risk of changes in costs per member to Optum. This risk made Optum accountable for ensuring services are effective and efficient.

Optum continued to pay providers enrolled in the Idaho Behavioral Health Plan on a fee-for-service basis, though it piloted a program to pay providers extra based on the quality of the providers' outcomes. Using outcomes as a basis for payment would be a first step in holding providers directly accountable for the health outcomes of their patients.

Optum continued to pay providers enrolled in the Idaho Behavioral Health Plan on a fee-for-service basis.

The department wanted the Idaho Behavioral Health Plan to reform the outpatient behavioral health system.

The department and stakeholders expected the Idaho Behavioral Health Plan to increase accountability of the payer, providers, and members.

The Idaho Behavioral Health Plan was significantly larger in scale than any of the state's other managed care efforts. The department saw the Idaho Behavioral Health Plan as a means of determining: (1) the extent to which it could reform the outpatient behavioral health system given previous reform difficulties and (2) lessons and prospects for future managed care efforts.

The department, the Legislature, and the community expected the Idaho Behavioral Health Plan to increase accountability of the payer, providers, and members. They also hoped managed care would introduce new services and ensure existing services were delivered with fidelity to evidence-based practice and the department's goal for a behavioral health system focused on recovery and resiliency.

As long as the state could make sure that people who need care get care, providing effective and efficient services is in the vendor's best interest.

As long as a state can make sure that people who need care get care, providing effective and efficient services is in the vendor's best interest. The vendor's utilization management and network development would hold providers accountable for good business and clinical practice. Additionally, the vendor and providers could hold members accountable by making sure they did not access services inappropriately.

Basics of recovery and resiliency

For adults, the department's vision was to promote recovery as adopted from SAMHSA, the federal substance abuse and mental health authority. SAMHSA's standards for evidence-based services that promote recovery include 10 fundamental components that "enable members to be not only in charge of their illness, but also in charge of their lives."

For children, the department's vision was a focus on resiliency. The department defines resilience as positive adaptation to significant adversity that incorporates the child's unique characteristics and resources.

A successful behavioral health system focused on recovery and resiliency provides members with services that help them build natural supports that reduce their need for constant services.

Utilization and network management are key transformation tools of the Idaho Behavioral Health Plan.

Successful utilization management improves outcomes while controlling costs by providing the right care at the right time.

Managed care is a complex arrangement of incentives, tools, and mechanisms that serve as the functional components which shape and manage a health care system. Through utilization management, network management, and network monitoring, the vendor can help make sure services are delivered efficiently. The design and implementation of each component determines how managed care affects Idaho's behavioral health system.

The department wanted to ensure that services members received were evidence-based practices for achieving members' recovery goals. Optum focused its bid on the department's goals and adapted its utilization management from its national standards to incorporate Idaho's service descriptions. In the long term, successful utilization management improves outcomes while controlling costs by providing the right care at the right time.

The process of clinical review, which requires providers to demonstrate medical necessity, is critical for utilization

Evidence-based practices: Approaches to prevention or treatment that have undergone scientific evaluation and shown to be effective.

Medical necessity: A legal concept for activities that may be justified as reasonable, necessary, or appropriate using evidence-based clinical standards of care.

Idaho Administrative Code says a service is medically necessary if (a) it is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunction; (b) there is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly; and (c) medical services must be of a quality that meets professionally-recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the department upon request.

management and has been a significant change in the way providers operate. Together, evidence-based practices, medical necessity, and utilization management are a potent force in managed care and have had a stronger effect on Idaho's behavioral health system than any other aspect of managed care.

The intensive clinical review of managed care is a major change for providers and can motivate them to change their practice in desired and undesired ways:

- Providers may alter their clinical practice to meet clinical guidelines required by the vendor for services to be authorized.
- Providers may alter their practices based solely on the fact that someone is watching them—a sentinel effect.
- Providers may alter their clinical practice by choosing not to request services they believe are clinically justified because of the hassle of the approval process. This is enough of a concern that vendors have controls to prevent providers from such practices.
- The vendor can offer pay-for-performance quality incentives or selectively contract with service providers whose services align with their clinical guidelines.
- Providers who most easily adapt to these changes are more likely to remain in business.

In addition to clinical reviews, Optum uses the following network management methods to shape service utilization:

- Regional field coordinators intended to coordinate providers, members, and community resources to ensure members are accessing the most beneficial services.
- Quality assurance and quality improvement processes focused on the needs of members and their families, contract requirements, and federal regulations.
- Provider trainings, including medical necessity and evidence-based practices.
- Recommendations for changes in treatment plans.
- ALERT, a system to measure patient outcomes and provider effectiveness. Providers can review the ALERT data for their patients.

Evidence-based practices, medical necessity, and utilization management are a potent force in managed care and have had a stronger effect on Idaho's behavioral health system than any other aspect of managed care.

The intensive clinical review of managed care is a major change for providers and can motivate them to change their practice.

The Idaho Behavioral Health Plan has controlled spending.

Savings have come from reduced spending per person, not from reducing the number of people receiving services.

Implementation of the Idaho Behavioral Health Plan has led to a decrease in overall spending. In February and March 2015, the most recent months we have data, Optum paid providers $17.7 million for services. This trends out to $28 million less annually than the department was spending before adopting the Idaho Behavioral Health Plan. Adjusting for increases in Medicaid enrollment, it trends out to $43.4 million less annually than the department would have spent.

Exhibits 2, 3, and 4 describe aggregate and member-level changes in spending.

Exhibit 2

Most of the effect of utilization management has been seen in the reduction of PSR.

Excludes Federally Qualified Health Center spending.

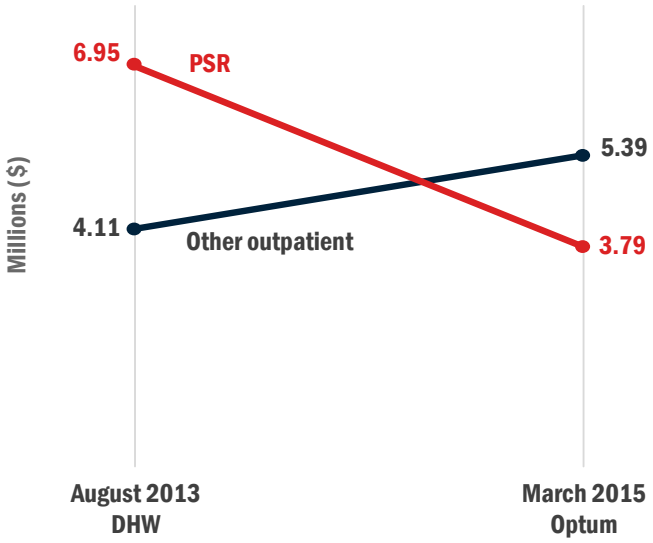


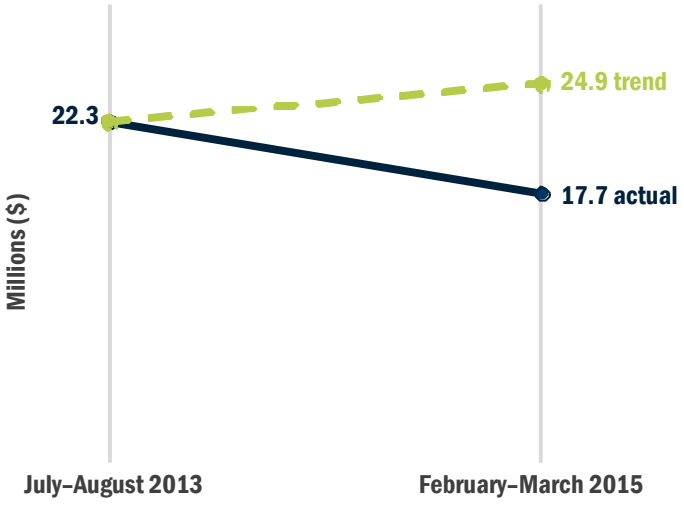
Exhibit 3

Reductions in spending were most pronounced among children.

	July–August 2013 Paid by the department		February–March 2015 Paid by Optum	
Group	Total spending ($)	Spending per member ($)	Total spending ($)	Spending per member ($)
All members	22,347,099	45.64	17,680,844	33.81
Elderly and disabled	10,600,365	114.69	9,263,641	101.21
Children	9,134,247	27.93	6,090,289	16.83
Adults and disabled workers	1,660,226	27.29	1,654,357	28.94
Foster children	952,261	115.56	672,558	84.30

Exhibit 4

Optum has reduced spending on services since it began administering the Idaho Behavioral Health Plan.



As exhibit 5 shows, savings have come from reduced spending per person, not from reducing the number of people receiving services. As of February–March 2015, about the same proportion of members were receiving services as were receiving services in July–August 2013 when administered by the department.

Exhibit 5

Optum served about the same proportion of Medicaid members that the Division of Medicaid had served.

	Served by the division July–August 2013 (%)	Served by Optum February–March 2015 (%)
All members	8.8	8.7
Elderly and disabled	19.2	19.9
Children	5.8	5.7
Adults and disabled workers	6.8	8.0
Foster children	24.0	24.8

As hoped by the department, some Idaho Behavioral Health Plan services have increased in use.

Family therapy has increased since the beginning of the Optum contract. As of March 2015, family therapy was being provided to more children than was PSR. For adults, reductions in PSR have been accompanied by increases in family therapy and a small amount of peer support (includes community transition support). Total spending and a count of unique members who received services is in exhibit 6.

Exhibit 6

PSR's significant decline has been accompanied by smaller increases in other services.

Comparison of the most recent month we have data (March 2015) from Optum with Optum's first month of operation (September 2013).

Selected service category	Spending Sept. 2013 ($)	Members served Sept. 2013	Spending Mar. 2015 ($)	Members served Mar. 2015
PSR/CBRS	6,836,220	10,559	3,798,274	7,368
Individual therapy	1,786,913	11,761	2,178,865	14,848
Case management	747,008	4,686	793,618	4,722
Family therapy	84,864	896	621,174	4,469
Planning and diagnostics	379,213	3,813	461,564	4,979
Drug testing and counseling	237,511	719	393,623	1,130
Prescriber office visits	284,213	3,813	352,031	4,746
Neuropsych testing	52,903	123	95,601	243
Peer support	180	1	88,918	269
Partial care	33,024	118	49,844	188
Psych testing	47,123	192	40,375	203
Crisis intervention	4,024	35	37,298	306
Group therapy	3,669	68	14,334	292

We found no evidence that the Idaho Behavioral Health Plan led to increases in services not covered by the plan.

Behavioral health systems generally involve multiple payers for a single person. State and county health systems, courts, and foster care might all compete to shift the responsibility for someone's behavioral health care costs to another entity. This competition, known as cost shifting, was a major concern of the Governor's work group in 2010: members were being denied lower-cost community services and ending up in higher-cost inpatient care. In a system where cost shifting occurs, implementing managed care can exacerbate the issue.

States control the cost shifting of managed care vendors by making the vendor responsible for costs. Most directly, states make the vendor responsible for a broad array of services—at least outpatient and inpatient services. If a vendor has to pay for a patient's crisis care and hospitalization, it has the incentive to provide lower-cost services to prevent the need for crisis care or hospitalization.

We did not complete a comprehensive investigation of every place a member could go if they were denied services under the Idaho Behavioral Health Plan and subsequently experienced a mental health crisis. However, we examined data provided by the Division of Medicaid and the Division of Behavioral Health which did not show unexplained increases above historical trends. The trend for most behavioral health services not covered by the Idaho Behavioral Health Plan had flattened or declined. Annual per member per month inpatient costs paid by the Division of Medicaid increased only 0.8 percent during the first year of the contract.

The trend for most behavioral health services not covered by the Idaho Behavioral Health Plan had flattened or declined.

Behavioral health plan limitations

4

Idaho has a limited continuum of care for behavioral health. The Governor's work group envisioned 20 services that would comprise the core of its continuum of care—to be available to anyone who needs it regardless of their geographic location or enrollment in Medicaid. Only 9 of the 20 services were part of the state's Medicaid plan.

The standard approach to a limited-benefit behavioral health plan has payment for inpatient and outpatient services integrated within the same plan. This approach helps patients move between levels of care and fills gaps between levels of care by providing intermediate services. Intermediate services increased the opportunities for patients to receive the right level of care. As of 2015, Idaho's state plan does not contain any more of the 20 services suggested by the work group, though the Idaho Behavioral Health Plan has introduced one of them.

The standard approach to behavioral health limited-benefit plans usually includes the full continuum of care.

National experts suggest that managed care best improves the quality of care and saves money when a single entity is responsible for the entire continuum of care, from outpatient to inpatient. Because inpatient care is expensive when compared with community-based services, the managed care vendor has a high reward for identifying members likely to use inpatient care and providing services that prevent the need for inpatient care. The vendor can use savings from inpatient care to improve the continuum of care.

Additional benefits arise from including the entire continuum of care in managed care. By putting a vendor at risk for the entire continuum of care, the vendor has incentive to develop more levels of care and smoother transitions for patients between levels of care. With supporting state policy, a vendor might develop more partial hospitalization, residential care, and intensive outpatient services, thus improving the chance that members are receiving the level of care best suited to their needs. With more levels of care, more people are served in the community, which is less costly and tends to result in better health outcomes. Integrating payment for the continuum of care can be a good step to integrating care for members, a major goal of the department.

By putting a vendor at risk for the entire continuum of care, the vendor has incentive to develop more levels of care and smoother transitions for patients between levels of care.

Integrating payment for the continuum of care can be a good step to integrating care for members, a major goal of the department.

Idaho chose to exclude inpatient services from the Idaho Behavioral Health Plan but tried to achieve similar benefits.

Idaho chose not to include inpatient care in its managed care contract making Idaho the only state with a statewide behavioral health carveout that excludes inpatient care. The department explained that it excluded inpatient services out of concern that "managed care contractors might choose the standard approach of focusing on [inpatient services] rather than on the issues with PSR."

Although the department did not integrate payment for the full continuum of care in the contract, it hoped to achieve some of the same benefits. Specifically, the department wanted the Idaho Behavioral Health Plan to help fill gaps in the behavioral health continuum of care and improve integration of health services.

The department included three key strategies in the Idaho Behavioral Health Plan to fill gaps in the continuum of care and improve service integration: value-added services, savings investment, and a holdback and incentive tied to inpatient growth.

Value-added services

The department included language in the contract directing Optum to bring new value-added services to Idaho. In the request for proposals, the department indicated it would like the vendor to include descriptions of new services the vendor would provide. The department pointed out 11 services not included in the state plan that would be necessary to complete a robust continuum of care. In its bid, Optum identified the following three new services as part of the behavioral health benefit package it would offer:

Peer support: Allows people who have experienced mental illness to provide support for others who are dealing with similar experiences. They assist members in identifying life goals and taking specific steps to achieve them.

Family support: Support from a family member of a child who has serious emotional disturbances and or issues with substance use can play a major part in helping another family

Idaho is the only state with a statewide behavioral health carveout that excludes inpatient care.

The department excluded inpatient services out of concern that managed care contractors might focus on inpatient services rather than on the issues with PSR.

maintain or regain its resiliency while their child is receiving mental health or substance abuse services.

Community transition support: During the first month after an individual is discharged from a hospital, it is critical the individual follows his or her discharge plan, begins outpatient treatment as indicated, uses medication as ordered, and begins to re-engage with family, friends, and other natural community support systems.

Implementation of these services has been limited by a lack of an existing provider base prepared to deliver and a lack of training to develop a provider base. Optum and the department have made efforts to introduce the service within those limitations.

As with all changes for managed care, these three value-added services depend on providers making changes to their practices. At a minimum, member understanding and expanded training for certification of support specialists are necessary to facilitate changes in provider practice.

In July–August 2013, the Division of Medicaid spent four times as much on PSR than it spent on inpatient care.

Savings and community investment

In most states behavioral health managed care savings usually come from reducing inpatient spending; Idaho, however, had a unique opportunity to reallocate resources. In July–August 2013, the Division of Medicaid spent four times as much on PSR than it spent on inpatient care. The significant and unusual amount of spending on PSR gave Idaho an opportunity to reallocate resources without relying on inpatient savings.

The department put an administrative cap on Optum and hoped any savings in excess of the cap would be invested in the community to strengthen the continuum of care by adding needed services and building network capacity.

Because of the department's 15% administrative cap, Optum does not earn additional money from additional savings.

The department's contract stipulated that Optum could only retain 15 percent of capitation payments. Because of the department's 15 percent administrative cap, Optum would not earn additional money from additional savings. In the 2014–2015 contract year, Optum earned its maximum administrative fee. When savings, measured in year-long periods, exceeds the 15 percent administrative cap, Optum is expected to use the savings in the community. The administrative cap frees resources for additional community improvement.

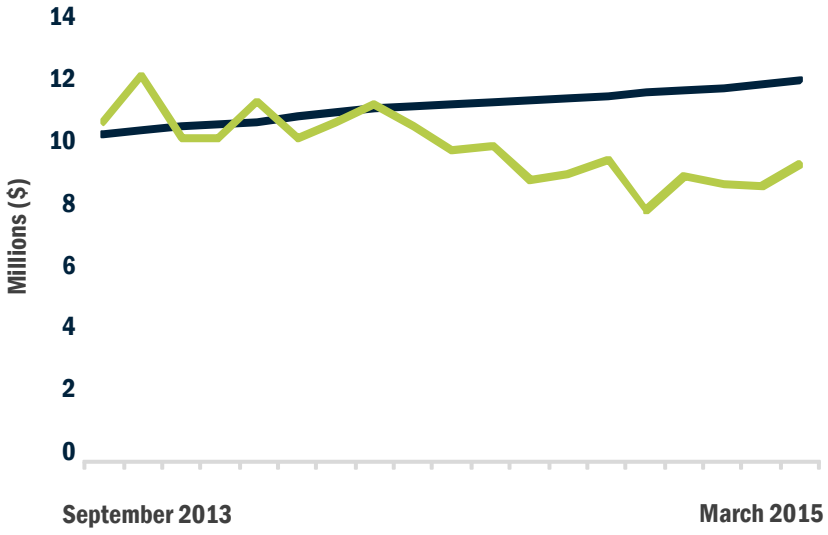
Spending in the contract's second year has fallen well below the 85 percent threshold. Optum's spending on services in February–March 2015 was an annualized $28 million less than the department had spent in the last months of the fee-for-service payment model. This decrease was in spite of approximately $1 million in annualized spending on new services, a 21 percent increase in spending on individual therapy, and a 630 percent increase in spending on family therapy.

Investment of savings has proved more difficult than the department originally anticipated because of the restrictive nature of federal regulations. The department and Optum are working together to create a plan to spend savings within the limitations of federal regulations.

Investment of savings has proved more difficult than the department originally anticipated.

Exhibit 7

In the 2014–2015 contract year, the department paid Optum more than Optum spent on services.



Incentive and holdback

The inpatient incentive is not equivalent to putting the vendor fully at risk or to integrating payment.

In addition to including service integration language in the contract, the department developed a holdback and incentive to discourage cost shifting and encourage the vendor to develop a full continuum of care and improve service integration.

In lieu of putting the vendor fully at risk for inpatient services, the Division of Medicaid holds back 5 percent of its per member per month payment for members not enrolled in Medicare. If inpatient costs for these members rise less than 5 percent compared with the previous year on a per member per month basis, the vendor receives the full holdback. In addition, the department pays Optum half of all savings if inpatient costs fall more than 5 percent. If per member costs rise more than 5 percent, the department deducts the cost increase from the Optum's withhold on a dollar-for-dollar basis.

The integration of payment has been shown to facilitate the integration of care.

We recognize that the department wanted to focus the vendor's attention on reforming the outpatient system while protecting against increases in inpatient care. The department's inpatient incentive makes the managed care vendor responsive to inpatient costs. However, the inpatient incentive is not equivalent to putting the vendor fully at risk or to integrating payment for the entire continuum of care. Putting the vendor fully at risk encourages the vendor to actively manage services through the full continuum of care. Additionally, the integration of payment has been shown to facilitate the integration of care.

Lessons and recommendations

5

The Idaho Behavioral Health Plan was the department's largest managed care effort and a significant change for the public behavioral health system. In designing the Idaho Behavioral Health Plan, the department focused on evidence-based outpatient services. Overreliance on PSR was a major concern of the department; the plan has been effective in reducing reliance on PSR through increased management of outpatient service utilization.

In addition to reducing reliance on PSR, the department wanted the plan to improve the continuum of care and improve service integration. There has been limited success in both areas because of federal limitations on reinvestment and difficulties with workforce development.

Both the successes and shortcomings of the Idaho Behavioral Health Plan represent opportunities for the department to improve its plans and communication about the future of behavioral health managed care. Further, the department has learned lessons from its experience implementing the Idaho Behavioral Health Plan that are valuable to all state agencies when designing complex policies that depend on contracting for successful implementation of those policies.

The department has learned lessons from its experience implementing the Idaho Behavioral Health Plan that are valuable to all state agencies.

Another managed care vendor would have likely implemented changes similar to those Optum implemented.

Clearly communicate plans and choices for key aspects of new programs.

The department has acknowledged that, while it believed it had sufficient plans for communication with stakeholders, there is never enough communication when undergoing a change of this magnitude. More stakeholder communication could prevent confusion about the objective of the change.

The department anticipated that some providers would be unhappy with the administrative burden of managed care, with new treatment guidelines and oversight, and with what the department saw as inevitable transition pains. Some stakeholders believed that much of the department's policy direction was instead Optum's operational choices. The department did not clearly communicate that another managed care vendor would have likely implemented similar changes.

We found a widespread lack of understanding of the department's choices leading up to managed care within the department, the Legislature, and the community. The department said that its leadership had a broad understanding of why the department chose to pursue its unique approach to managed care. However, this understanding would have been valuable among all stakeholders experiencing and observing change.

The Idaho Behavioral Health Plan was a significant change in how outpatient behavioral health was delivered, and the department hopes to incorporate managed care further. The only record of what the department believed about how managed care would change outpatient behavioral health was in the memories of the people responsible for the plan, many of whom are no longer at the department. The department would have been better able to learn about reforming outpatient behavioral health and administering managed care if the department had documented what it planned, assumed, and expected.

Program design should be well developed before going to contract.

Agencies are limited in their ability to shape a program after a contract is awarded. When contracting, the resources spent developing and implementing a plan should be proportional to (1) the amount of management responsibility an agency outsources when contracting and (2) the importance of the contract to program success.

Knowing both of these things requires the department to understand all the steps necessary for program success and who will be responsible for those steps. Before deciding to contract, the department should complete a program analysis to understand not just what the vendor will be responsible for, but what the department will continue to be responsible for and what it will be newly responsible for. If the program creates obligations for multiple divisions within the department or for external stakeholders, the department should ensure all parties are willing and prepared to fulfill their obligations.

When agencies first transition from delivering services in-house to delivering services through a vendor, a common failure is using the same personnel and skills to plan, contract, and manage the delivery of services by a vendor that the department had used to manage and deliver services in-house. The skills necessary to plan and manage a project and to write and enforce a contract are distinctly different from those necessary to directly provide the service. The department and all agencies engaging in a complex program that primarily relies on contracting should make sure they have the skillset and expertise appropriate for the task. The department relied on existing program staff to develop and monitor the plan and contract. The department has since taken steps to strengthen its contract monitoring processes and team.

The department relied on existing program staff to develop and monitor the plan and contract. The department has since taken steps to strengthen its contract monitoring processes and team.

Expect some difference between program design and vendors' products, and plan for necessary adjustments.

The department has learned that vendors often have fairly well-defined products and capabilities. No product will perfectly align with a program's design and needs. Vendors will generally have to customize their products to some degree. However, if the services or approaches asked for fall outside a vendor's capabilities, the department would be likely to pay more for them and the vendor would be likely to struggle with how to implement them.

The department should plan for sufficient subject-matter and business expertise.

The department should plan for sufficient subject-matter expertise to understand the industry standard product and the business expertise to ensure that the department is sufficiently specifying key program features and can anticipate whether the services or approaches desired fall outside of a vendor's capabilities.

Use of an independent third-party consultant can be valuable especially when contracting for a newly designed program. The department understands this need and has used such consultants when designing other programs, such as the Statewide Healthcare Innovation Plan (SHIP). Additionally, the department should use the limited opportunities allowed by the Division of Purchasing to make sure the department and the contractor both understand the product being offered.

Use of an independent third-party consultant can be valuable especially when contracting for a new program design.

Regardless of program design and internal capacity, communication and collaboration are critical for contract success. The department has reinforced this lesson noting "that having a good professional and highly collaborative relationship between state and contractor staff is extremely important. This has been a key to our success on other managed care contracts. Building a shared understanding of goals with the contractor from the very first meeting should be a top priority." The department is working on reinforcing this concept among its staff who manage and monitor its contracts. Collaboration has been important for the department and Optum as they have worked to overcome barriers to the delivery of value-added services and investment of savings.

We recommend the department formally evaluate whether including inpatient services in the Idaho Behavioral Health Plan has merit.

The department's intent of excluding inpatient services from the Idaho Behavioral Health Plan was to focus vendor attention on the outpatient system—a plan which has been fairly successful. Now that the department's concern over PSR has been significantly addressed, one of the most important questions remaining about the Idaho Behavioral Health Plan is whether to include inpatient services.

Our report has discussed some of the potential benefits from integrating the payment of services: the vendor incurs the full expense or benefit from the entire continuum of care and the coordination of care for members along levels of care is better. Integration of payment would appear to be a possibility for advancing the department's goal of integrating care. Although there are potential benefits from integrating payment for the entire continuum of care, we recognize there may be Idaho-specific barriers and concerns. Additionally, the population served by behavioral health services is vulnerable and requires policy to be implemented with caution.

To determine whether to expand the Idaho Behavioral Health Plan to the full continuum of care, we recommend the department formally evaluate the merit of including inpatient services in the Idaho Behavioral Health Plan. A formal evaluation will enable the department to make a deliberate, informed decision.

The evaluation should include clear documentation of the department's reasons and goals for either including or excluding inpatient services. The department's decision whether to include or exclude inpatient services will determine the mechanisms available for reform. Therefore, the department should compare the mechanisms available in each option and determine which option most effectively meets the behavioral health system's needs. In addition, the evaluation should clearly document expectations, barriers, and resource needs, including the following:

The population served by behavioral health services is vulnerable and requires policy to be implemented with caution.

A formal evaluation will enable the department to make a deliberate, informed decision.

Expected outcomes
Potential unintended consequences
Scale of opportunity
Barriers to inclusion of inpatient
State resources needed to support change
Change management needs
Change management capacity

A deliberate approach such as this should be taken, not just for the decision to include inpatient services, but for any project of this size, complexity, or level of risk. A formal evaluation will enable the department to make a deliberate, informed decision and clearly communicate plans and choices for key aspects of new programs; have a well-developed program design before going to contract; and expect some difference between program design and vendor's products and plan for necessary adjustments.

We also recommend the department use independent third-party expertise for assistance in planning and designing the transition.

Study request

A

Rep. John Rusche

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House of Representatives
State of Idaho

MINORITY LEADER

Dear Joint Legislative Oversight Committee,

There have been almost continuous complaints about behavioral health services managed under the DHW Medicaid contract with Optum Idaho. There appears to be a significant difference in view depending on who is the observer—patients, providers, Optum, or our own department. As a representative, it is very difficult to reconcile these.

After hearing what sounds like significant problems in the system established by the Optum/DHW/Medicaid contract, I have several questions.

1. To what extent does the limited contract cause or aggravate things? The fact that a managed care company is charged with managing a limited set of "covered" benefits and not the entire spectrum of care appears problematic.
    a. Is this approach (risk for limited outpatient services) standard in Medicaid plans?
    b. How are services within the Optum contract integrated with other behavioral health services, such as medication, hospital care, and other services?

2. Utilization Management has been an issue.
    a. Are Optum's protocols consistent with other UM protocols in other states, and are these states regarded as successful?
    b. How are the protocols communicated, or how is the fact that they're 'best practices' communicated?
    c. Do appeals conform to law? Are they industry standard/best practice?

3. It has been difficult to acquire data on these patients, not just for behavioral health services but also for other publically funded services, from ER and Community hospitalization to hospital readmits court, and public safety expenses. Does H&W have systems in place to measure the effectiveness and cost of the managed BH effort?

4. Are the recovery models used standard for chronically ill patients?

Thank you for considering this important issue.

Sincerely,

Rep. John Rusche
Minority Leader

Study scope

B

Evaluation background

Over the past decade, Idaho formed working groups and conducted studies to identify strategies to slow rising Medicaid costs and meet demand for Medicaid benefits. In 2011 the Legislature directed the Department of Health and Welfare to change its Medicaid payment model from fee-for-service to managed care.

Medicaid provides physical and behavioral health care benefits for low-income children and adults. Managed care assigns responsibility for Medicaid members' service availability and payment to one or more managed care organizations; in exchange, usually, Medicaid pays the organizations a set per member, per month fee.

Medicaid's behavioral health benefits include inpatient and outpatient treatments for mental health and substance use disorders. The Idaho Behavioral Health Plan, which covers a portion of behavioral health benefits, is one of the department's first managed care efforts. In 2013 the department awarded Optum Idaho a three-year, $300 million contract to manage Medicaid payments for behavioral health but limited the contract to outpatient services; payments for inpatient services remained under the department's administration.

Concerns about policy implementation and contract execution

One way managed care can improve quality while decreasing costs is by bundling high-cost services with low-cost services under a single contract. Idaho's contract with Optum excludes some high-cost services, and policymakers are uncertain about the consequences.

Optum has been the subject of several news stories and complaints by providers. Service providers reported problems where Optum paid very slowly or substantially less than providers expected. Some providers received checks for pennies on the hundreds of dollars, and some providers reported spending significant time on hold when trying to get authorization to provide a service.

During the 2015 legislative session, the Joint Legislative Oversight Committee received a study request expressing concerns about the department's decision to limit the contract for managed care to outpatient behavioral health and Optum's performance and management of services. The committee unanimously approved the study at its March meeting.

Evaluation approach and objectives

We will first determine whether the Idaho Behavioral Health Plan is achieving the results expected by the department. After we have determined the effects of the Idaho Behavioral Health Plan, we will identify factors that have had a significant positive or negative effect on program success. This will include evaluating the department's design for the Idaho Behavioral Health Plan and its implementation by the department and Optum. We expect that success of the Idaho Behavioral Health Plan will be most influenced by

- the scope of services included in the department's behavioral health managed care contract;
- the department's plan for integrating benefits managed under the Optum contract with benefits not managed under the contract, such as inpatient and pharmacy;
- the recovery and resiliency model for the chronically ill as implemented by Optum;
- the department's preparing stakeholders and fostering their buy-in;
- the department's systems, methods, and capacity for ensuring program success;

Optum's management of expected problems and its responsiveness to unexpected problems reported by stakeholders;

the department's methods for ensuring patients receive medically necessary behavioral health care; and

Optum's utilization management, including its appeals process and communication to stakeholders about utilization management and its potential benefits.

C Methodology

With an evaluation of this scope, much of our fieldwork was background research and narrowing the report's focus in order to produce a document useful to all parties involved. All of the work shaped what we chose to include or exclude from the report, even if the work is not explicitly in the report.

We used the following methods during fieldwork.

Stakeholder outreach

We interviewed more than 100 people. We talked with mental health and substance use disorder treatment providers in all seven Health and Welfare regions of the state—from those in small two-person clinics to those in large health centers. We spoke with many where Optum was their first managed care experience and others who had done business with managed care organizations in other states. We spoke with many at the department and at both Optum's Idaho office and its national offices. We received unsolicited correspondence from behavioral health advocates, providers, and even those within state government.

Because of the department's lack of documentation about its choices to move to managed care, we used interviews as primary sources. Our discussions with providers raised a number of concerns with us, but ultimately the department's contract monitoring and quality assurance teams demonstrated independent knowledge of each of these concerns.

Document review

The reports by Western Interstate Commission for Higher Education (WICHE) and the Governor's work group helped us

understand stakeholder concerns and priorities for the behavioral health system. Subsequent legislation and legislative history told us how, if at all, the Legislature implemented these priorities through legislation.

We reviewed contracts, policy statements, and Medicaid plans of other states. We used our 2013 evaluation of contract management and additional documents to guide our analysis of the department's contracting process. We used documents by federal authorities and private research groups to guide our understanding of successful managed care. We reviewed all of the periodic reports of the department's contract monitoring and quality assurance teams, which were initially provided weekly and subsequently provided monthly or quarterly. Additionally, we reviewed all of the documents in the department's contract, including the scope of work and Optum's bid. We also reviewed documents from Optum and the department on select topics as needed for additional supporting evidence.

Data analysis

We received several large data sets, mostly of individual claims-level data, from the department and Optum. Using a SQL database, we created datasets for data from both Optum and the department, the largest of which included 5.8 million rows and over 30 fields describing claims data for 65,113 unique members. We combined this claims-level data with member-level data. Because the member-level data included several records for many members, we matched specific claims to the specific member records using claim dates and dates of enrollment changes.

We realize claims data is an imperfect proxy for the actual clinical experience of patients and that the relationship between the data and reality depends on whether providers report the services being provided. The claims data could overrepresent services provided if fraud and integrity efforts did not catch them; the claims data could underrepresent services if, as a number of providers reported, providers offered services *pro bono* to Medicaid members whose requests for a service were denied.

D Psychosocial rehabilitation

Mental health rehabilitative services were introduced to the Medicaid benefit package July 1, 1994, and were called the community-support program. This history of the PSR benefit is adapted from a document provided by the Division of Medicaid.

1995

Initially, department regional staff conducted comprehensive assessments and developed initial service plans based on the comprehensive assessment and then referred the Medicaid participant to a community provider of the participant's choice. The community provider had to be enrolled in the Medicaid program as a rehabilitation provider. The rehabilitation provider completed the service plan by developing a task plan, which identified time-limited, measurable activities and assignments, to accomplish the objectives of the service plan.

The responsibility to review, approve, and authorize requests for prior authorization and the accompanying service plans was delegated by respective program managers to a unit supervisor, a review team, or a specifically appointed individual called the regional mental health authority. The regional mental health authority prior authorized the plan and the provider subsequently delivered the service and billed Medicaid.

2002

Following budget cutbacks in 2002, the assessment and treatment planning services for what had been renamed psychosocial rehabilitation were outsourced to the community provider network. Mental health authority staff was downsized to two staff members in each region. One authorized services for the adult Medicaid participants, and one authorized services for the child Medicaid participants. This was the beginning of the dramatic increase in the use of psychosocial rehabilitation.

2004

In 2004 Idaho Administrative Code was updated to include more specificity for application of the PSR benefit and standards for treatment planning (IDAHO ADMIN. CODE 16.03.09.449-459 (2004)).

The PSR authorization and auditing functions of the regional mental health authorities were brought under the supervision of one unit, the Mental Health Authority, located in Boise. Authorization functions for the entire state were handled in Boise. Each region retained one clinician, now supervised by the unit supervisor in Boise, to work with adult and children PSR agencies in its region.

2005

The Legislature passed House Bill 385 granting the Division of Medicaid authority to establish program credentialing mental health agencies, which ensured mental health clinics and PSR providers met quality standards, utilized qualified providers, and provided appropriate services that met the needs of Medicaid participants.

2007

The Division of Medicaid developed a credentialing program, the goal of which was to set a minimum standard of care for all Medicaid-reimbursed mental health services, including professional ethics standards for all agency employees, whether licensed or not (IDAHO ADMIN. CODE 16.03.09.712 and 16.03.10.130.09 (2007)).

2008

Fifteen FTEs of the Mental Health Authority were transferred to the Division of Medicaid from the Division of Behavioral Health to promote better oversight and administration of the PSR benefit. Eight FTEs were assigned to the Medicaid central office and seven FTEs, one located in each region, were assigned to work in the new Medicaid credentialing program.

2009

Because of budget holdbacks, the hard limit of the PSR benefit was set to 10 hours a week (House Bill 701) (IDAHO ADMIN. CODE 16.03.10.124.05 (2008)). The Division of Medicaid discovered that only a small proportion of Medicaid participants accessing PSR were also accessing psychotherapy services.

Quality assurance processes were put in place to identify issues and to serve as an educational tool via feedback. Quality assurance results revealed that providers were applying the PSR benefit in a variety of ways significantly supporting Medicaid participants to stay out of hospitals and remain in their community roles (family, school, natural supports) and to experience recovery and resiliency from crises in their lives. Quality assurance results also confirmed that the benefit continued to be applied inappropriately by some providers.

In 2009 Idaho Administrative Code was updated to account for credentialing program rules and clients' rights to safe and appropriate treatment by competent providers (IDAHO ADMIN. CODE 16.03.09.707–718 and 16.03.10.110–146 (2009)).

On May 8, 2009, requirements again changed for PSR specialists. PSR specialists who were currently employed had until January 1, 2012, to become certified as PSR specialists in accordance with requirements of the US Psychiatric Rehabilitation Association (USPRA). To become PSR specialists, applicants had to have a bachelor's degree in primary education, special education, adult education, counseling, human services, early childhood development, family science, psychology, or applied behavioral analysis. Qualified new hires had 18 months to obtain the USPRA certification (IDAHO ADMIN. CODE 16.03.10.131.03 (2009)).

To accommodate additional Governor's holdbacks, the hard limit of the PSR benefit was again reduced on May 8, 2009, to 5 hours a week with up to 5 additional hours a week with prior authorization (IDAHO ADMIN. CODE 16.03.10.124.05 (2009)).

In 2009 a utilization management program was put in place to ensure that participants whose PSR benefit was reduced did not subsequently need to access crisis services, inpatient hospitalization, or the emergency department. No increase in the utilization of these higher-cost services occurred.

2011

The PSR benefit was limited to 5 hours a week. Participants who receive psychosocial rehabilitation could not also receive skill training in partial care, developmental therapy, intensive behavioral intervention, or residential habilitation services. (IDAHO ADMIN. CODE 16.03.10.124.06 (2011)).

2012

Because of the third Governor's holdback, the hard limit of the PSR benefit was reduced again to 4 hours per week for adults 21 years or older and 5 hours as a baseline for children up to age 21 (early and periodic screening, diagnostic, and treatment process ensured no hard limit for children). Idaho Administrative Code was adjusted to accommodate this change (IDAHO ADMIN. CODE 16.03.10.124.06 (archive 2012)). Again, there was no increase in the higher-cost services as listed above.

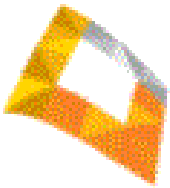
Responses to the evaluation

The report appropriately focused on better communication efforts, a well-developed program design and planning for adjustments.

—Butch Otter, Governor

We appreciate your fair and balanced approach to this study and your commitment to producing a report that is factual and accurate.

—Richard Armstrong, Director
Department of Health and Welfare



Optum Idaho thanks the Office of Performance Evaluations for its in-depth study of the Idaho Behavioral Health Plan.

—Becky diVittorio, Executive Director
Optum Idaho

C.L. "BUTCH" OTTER
GOVERNOR

January 12, 2016

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St.
Boise, ID 83702

Dear Rakesh,

Thank you for the opportunity to respond to the draft report, Design of the Idaho Behavioral Health Plan.

I appreciate the evaluation and insights regarding the Department of Health and Welfare's efforts to implement behavioral health managed care for Medicaid recipients.

The report appropriately focused on better communication efforts, a well-developed program design and planning for adjustments. These are suggestions that will assist Health and Welfare in strengthening the program and preparing for future managed-care efforts.

Additionally, I have confidence in the department's ability to evaluate whether inpatient services should be included in the Behavioral Health Plan.

Thank you again for your study of Idaho's efforts to address issues related to behavioral health and the Department of Health and Welfare's implementation of a new system of care.

As Always – Idaho, "Esto Perpetua"

C.L. "Butch" Otter
Governor of Idaho

CLO/tp

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER - GOVERNOR
RICHARD M. ARMSTRONG - DIRECTOR

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January 11, 2016

Rakesh Mohan, Director
Office of Performance Evaluations
954 W. Jefferson St.
Boise, ID 83720

Dear Director Mohan:

Thank you for the opportunity to respond to your study on the Idaho Behavioral Health Plan (IBHP). While the implementation of this managed care plan has been successful, it did bring substantial changes to services that have significantly affected Medicaid providers and participants. No change of this magnitude occurs without controversy. We appreciate your fair and balanced approach to this study and your commitment to producing a report that is factual and accurate.

We have reviewed your report and agree with its conclusions. The Department's goal in implementing the IBHP was to create a cost-effective, evidence-based system of behavioral healthcare with a focus on recovery and resilience. While we have largely achieved that goal, we recognize that these changes have not been easy for certain providers and for some of the participants we serve.

There are still many opportunities for the Department and our contractor to improve both the effectiveness and the availability of the services provided under the IBHP. As the changes implemented through the IBHP have stabilized, we have begun working with Optum on plans to improve and expand the behavioral health resources available to Medicaid participants and providers. Some changes in the form of increases in provider fee schedules and the implementation of a program to pay for quality care are in progress or already completed. We are looking forward to implementing additional improvements, including new benefits, in the near future.

The feedback contained in this report is valuable to us as we continue to work on managing the IBHP as effectively as possible. We agree that communication around new programs, well-developed program design, and planning for adjustments between program design and vendor products are all vital components for successful contract implementation. Medicaid has been

working for several years to improve our capabilities with respect to managed care contracts. We will continue these efforts with focus on these key areas to better meet Idaho's needs.

We also agree with your recommendation to formally evaluate whether including inpatient services in the IBHP has merit. We will work with our staff and our financial, utilization management, and data analytics contractors to examine our inpatient psychiatric hospital data and IBHP data to identify opportunities for care improvements that would prevent unnecessary hospitalizations. We will also work with provider associations and participant community representatives to assess the opportunities with respect to inclusion of inpatient services in the plan. We intend to complete this evaluation by the end of 2016 and will share our recommendation with the Joint Legislative Oversight Committee and your office.

Thank you again for the hard work and thoughtful approach that went into this report.

Sincerely,

RICHARD M. ARMSTRONG
Director

RMA/af

OPTUM

205 E. Water Tower Lane
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January 12, 2016

Rakesh Mohan, Director
Idaho Legislature, Office of Performance Evaluations
954 W. Jefferson Street
Boise, ID 83720

Dear Mr. Mohan:

Optum Idaho thanks the Office of Performance Evaluations (OPE) for its in-depth study of the Idaho Behavioral Health Plan (IBHP). Optum is committed to improving the behavioral health system, and studies such as this help identify opportunities that can help better serve stakeholders and improve member care.

When Optum entered into our agreement with the State, we had one goal in mind: Transform the outpatient mental health and substance use system to better help people reach recovery. Recovery-based care focuses on the individual and customizes treatment plans and programs for that person, taking into account his/her goals and strengths. Recovery-based care draws on evidence and treatments that are known to work. This could include individual therapy, family therapy or peer support services and is based on national standards of practice, as indicated in the OPE study.

By working collaboratively with the Idaho Department of Health and Welfare, our network of providers, members and community representatives, Optum is seeing transformational changes within the behavioral health system. We are encouraged by the support among stakeholders for making improvements that will better serve the people of Idaho, and we will continue to work with our partners on this important mission.

As stated in the OPE study, Optum has consistently executed on its contract commitments and is helping Idaho create a stronger behavioral health care system. With a focus on recovery-based care, Optum is committed to bringing more programs and services to the outpatient behavioral health system, including:

1. **Measuring member satisfaction to receive feedback for continuous improvements.** Optum initiated a survey to better engage members who access services and gather direct feedback from the members themselves about their experiences, to drive continuous improvements. The overall experience of members participating in the surveys has consistently been strong. Most recently, members report over 94% satisfaction with their overall experience (Mar – Jun 2015).

2. **Establishing a robust quality assurance and performance improvement program with active participation from key stakeholders including members, providers, families and community advocates.** Optum's quality assurance program is multi-faceted, with internal and external components that ensure transparency and continued performance improvement.

3. **Supporting members with high health care needs across all seven Idaho regions with the introduction of Field Care Coordinators who have consulted with providers on more than 900 member cases.** Additionally, Optum implemented a wellness assessment program, ALERT, which has driven more than 17,000 outreaches to providers to support effective care treatment options for members.

4. **Expanding provider access and Telehealth services.** We continue to enhance access to care by promoting telepsychiatry services to meet a variety of care needs, including for medication management services. This means rural and remote regions of Idaho receive services that may not otherwise be easily available.

5. **Delivering new tools and support mechanisms for members and providers**. Programs such as our new InTouch Community Discussion series help families understand best practices in addressing specific health challenges.

We are particularly pleased with the outcomes that have resulted from the combined efforts of Optum, our network of providers and State leaders, specifically:

- An **87%** increase in the use of parenting skills training through Family Therapy benefits (7,565 to 14,304 unique participants from SFY2014-SFY2015).

- A **24%** increase in the amount of individual therapy services delivered to all members (24,305 to 30,139 unique participants from SFY2014-SFY2015).

As the above numbers represent and as indicated in the OPE study, we are seeing a shift of outpatient services delivered to children. This indicates more families are engaged in helping their loved ones reach recovery, and families are now taking a more active role in that journey.

We are excited about the many opportunities ahead as we work collaboratively with State leaders, our network of providers, provider associations and members. On January 1, 2016, we implemented our pay for value program with the provider network to align incentives for outcomes. We look forward to implementing new community health initiatives with money saved through the effective management of our contract. The initial focus of these efforts will be on improving the quality of care provided to Idahoans through helping providers with change management support services. We are also collaborating with the state on enhancing the continuum of care for members.

Whether it is through community engagement activities, face-to-face discussions, informational media coverage or organized events, Optum remains dedicated to raising awareness about mental health and wellness and the resources available to help people reach recovery.

Sincerely,

Becky diVittorio

Becky diVittorio
Executive Director

Reports of the Office of Performance Evaluations, 2013–present

Publication numbers ending with "F" are follow-up reports from previous evaluations.

Pub. #	Report title	Date released
13-01	Workforce Issues Affecting Public School Teachers	January 2013
13-02	Strengthening Contract Management in Idaho	January 2013
13-03	State Employee Compensation and Turnover	January 2013
13-04	Policy Differences Between Charter and Traditional Schools	March 2013
13-05F	Coordination and Delivery of Senior Services in Idaho	March 2013
13-06	Guide to Comparing Business Tax Policies	June 2013
13-07F	Lottery Operations and Charitable Gaming	June 2013
13-08F	Governance of EMS Agencies in Idaho	June 2013
13-09F	Equity in Higher Education Funding	June 2013
13-10F	Reducing Barriers to Postsecondary Education	June 2013
13-11	Assessing the Need for Taxpayer Advocacy	December 2013
13-12	The Department of Health and Welfare's Management of Appropriated Funds	December 2013
14-01	Confinement of Juvenile Offenders	February 2014
14-02	Financial Costs of the Death Penalty	March 2014
14-03	Challenges and Approaches to Meeting Water Quality Standards	July 2014
14-04F	Strengthening Contract Management in Idaho	July 2014
15-01	Use of Salary Savings to Fund Employee Compensation	January 2015
15-02	The State's Use of Legal Services	February 2015
15-03	The K–12 Longitudinal Data System (ISEE)	February 2015
15-04	Idaho's Instructional Management System (Schoolnet) Offers Lessons for Future IT Projects	March 2015
15-05	Application of the Holiday Leave Policy	March 2015
15-06	Distribution of State General Fund Dollars to Public Health Districts	December 2015
15-07F	State Employee Compensation and Turnover	December 2015
16-01	Design of the Idaho Behavioral Health Plan	January 2016

Reports are available from the OPE website at www.legislature.idaho.gov/ope/
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